From: 05/23/2011 15:25 05/17/2011 14:33 8655945739 HEALTH CARE FACILITY PAGE 05/42 DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 05/16/2011 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A BUILDING 445383 B. WING NAME OF PROVIDER OR SUPPLIER 05/12/2011 STREET ADDRESS, CITY, STATE, ZIP CODE UNITED REGIONAL MEDICAL CENTER NURSING HOME 1001 MCARTHUR DRIVE MANCHESTER, TN 37355 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE ID PREFIX TAG (X5) COMPLETION DATE DEFICIENCY) F 159 483.10(c)(2)-(5) FACILITY MANAGEMENT OF F159 F 159 613111 PERSONAL FUNDS SS=F Upon written authorization of a resident, the This facility does, upon written facility must hold, safeguard, manage, and authorization of a resident, hold, account for the personal funds of the resident safeguard, manage, and account for deposited with the facility, as specified in the personal funds of the resident paragraphs (c)(3)-(8) of this section. deposited with the facility. The facility must deposit any resident's personal On 5/11/2011, all residents having funds in excess of \$50 in an interest bearing money in the resident trust account, account (or accounts) that is separate from any of the facility's operating accounts, and that credits from 1/1/2011 through 3/31/2011, all interest earned on resident's funds to that had interest allocated as of 3/31/2011 account. (In pooled accounts, there must be a by the Business Office Manager. separate accounting for each resident's share.) Any resident having money in the The facility must maintain a resident's personal resident trust account will have the funds that do not exceed \$50 in a non-interest potential to be affected. bearing account, interest-bearing account, or The Business Office Manager or her petty cash fund. designee will be responsible for The facility must establish and maintain a system ensuring the interest is accrued quarterly. This will be done by

that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.

The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.

The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.

The facility must notify each resident that receives Medicaid benefits when the amount in the

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE

allocating interest accrued accordingly. Quarterly audits will occur by the Business Office Manager or her designee to ensure compliance. The results of these audits will be reported to the QA Committee quarterly by the Business Office Manager. The QA Committee will make recommendations and develop

monitoring the bank statement and

an action plan if areas of

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that Any denominary statement formular with an estate of 7 denotes a demonity which the institution may be exceed from contenting to determine the other safeguards provide Sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

FORM CMS-2567(02-69) Previous Versions Obsolete

Event ID: QZPF11

Facility ID: TN1601

If continuation sheet Page 1 of 32

HEALTH CARE FACILITY

PAGE 06/42

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 05/16/2011 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING 445383 B. WING

NAME OF	PROVIDER OR SUPPLIER				OE!	12/2011
UNITED	REGIONAL MEDICAL CENTER NURSING HOME	1 1	REET ADDRESS 1001 MCARTHL MANCHESTE			12/2011
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PRO (EACH	MDER'S PLAN OF CORRECT CORRECTIVE ACTION SHOUL EFERENCED TO THE APPRO DEFICIENCY)		COMPLETION DATE
	Continued From page 1 resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by:	F 159	consists o Assistant Medical D Activity D	liance are noted. The meets quarterly are the Administrator, DON, MDS Coordinarctor, Social Servicector, Business Ond others as indicated.	DON, nator, ices,	
t	Based on review of resident trust fund accounts the facility failed to ensure the accounts were credited with interest for twenty-four of wenty-four trust fund accounts reviewed. The findings included:				0000	**
a	Review of the trust fund accounts revealed wenty-four residents had trust funds in a pooled count in January and February 2011, with a stal balance of \$5,999.64 on February 28, 2011.					
re	eview of the Trust Fund Trial Balance dated ecember 1, 2010, through March 31, 2011, vealed interest was applied to the accounts on ecember 31, 2010, however, no interest was oplied to the accounts in March 2011.					
of chares reco	serview on May 10, 2011, at 2:30 p.m., with the siness Office Manager (BOM), in the Director Nursing's office, revealed the facility had a ange of ownership in March 2011, and the sident trust fund account was closed, and opened into a different account. Continued erview with the BOM revealed interest accrued March 2011 would be applied to the resident st accounts in July 2011. Continued interview	5		¥		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: QZPF11

Facility ID: TN1601

If continuation sheet Page 2 of 32

HEALTH CARE FACILITY 05/17/2011 14:33 8655945/39 PAGE 07/42 DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 05/16/2011 FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING 445383 B. WING NAME OF PROVIDER OR SUPPLIER 05/12/2011 STREET ADDRESS, CITY, STATE, ZIP CODE UNITED REGIONAL MEDICAL CENTER NURSING HOME 1001 MCARTHUR DRIVE MANCHESTER, TN 37355 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE ID PREFIX TAG (XS) COMPLETION TAG DATE DEFICIENCY F 159 Continued From page 2 F 159 confirmed the twenty-four residents with trust accounts in January and February did not receive credit for earned interest at the end of the quarter. 483.10(c)(7) SURETY BOND - SECURITY OF F 161 F 161 PERSONAL FUNDS SS=F 161 63111 The facility must purchase a surety bond, or This facility does purchase a surety otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal bond, or otherwise provide assurance funds of residents deposited with the facility. satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced All residents having funds in the Based on review of the surety bond, review of resident trust account have the potential bank statements, and interview, the facility failed to be affected. to ensure the surety bond was sufficient to ensure The surety bond was increased to the resident trust accounts. \$30,000.00 by 6/3/11 by the Administrator. The findings included: Audits will occur five times per week Review of the facility's surety bond revealed the times four weeks then weekly to ensure surety bond was issued on March 1, 2011, in the compliance by the BOM or her amount of \$15,000.00. designee. The results of these audits will be reported to the QA Committee Review of bank statements revealed the following quarterly by the Business Office totals of the resident trust accounts: March 3, Manager. The QA Committee will 2011=\$16,642.51; March 8, 2011=\$16,612.99; make recommendations and develop an March 9, 2011=\$16,595,21; April 1, 2011=\$18,583.26; March 5, 2011=\$19,274.73; action plan if areas of noncompliance May 3, 2011=\$20,759.95; and May 5, are noted. The QA Committee meets

FORM CMS-2567(02-99) Previous Versions Obsolete

F 164

2011=\$20,239,46.

Interview on May 12, 2011, at 11:35 a.m., with the Administrator, in the Administrator's office,

confirmed the surety bond was not sufficient to

ensure the resident trust accounts.

483.10(e), 483.75(I)(4) PERSONAL

Event tD: QZPF11

Feditty ID: TN1601

F 164

indicated.

quarterly and consists of the

Administrator, DON, Assistant DON,

MDS Coordinator, Medical Director,

Business Office Manager and others as

Social Services, Activity Director,

If continuation sheet Page 3 of 32

	05/17	7/2011 14:33 8655945739	HE	EALT	H CARE FAC	CILITY	PAGE	08/42
	DEPA	RTMENT OF HEALTH AND HUMAN SERVICE				/20011	FAGE	. 68/42
		TO VILLIAND VILLIAND VILLIAND VILLIAND	:S				PRINT	ED: 05/16/20
	AND PLAN	OF CORDER TO THE PROVIDED IN T					FOR	RM APPROVE VO. 0938-039
		IDENTIFICATION NUMBER		O MUE	TIPLE CONSTR	UCTION	(X3) DATE	E SURVEY '
				BUILD			COM	PLETED
	NAME OF	PROVIDER OR SUPPLIER	B, V	VING				
				ST	REET ADDRESS	S, CITY, STATE, ZIP CODE	05	5/12/2011
ŀ		REGIONAL MEDICAL CENTER NURSING HOME	:		.za i mendiili	UK UKIVE		
ı	(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES				R, TN 37355		
l	TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PRE		PRO	VIDER'S PLAN OF CORRECT	TION	
ŀ		THIS INFORMATION)	TA		CROSS-R	REFERENCED TO THE ABBO	ULD BE	COMPLETION DATE
	F 164	Continued				DEFICIENCY)	·	ONIE
	SS=D	Continued From page 3	F	164	F164			T
		PRIVACY/CONFIDENTIALITY OF RECORDS	3 '	104	1104			63111
	1	The resident has the sink to			This C. "	:2 ·		
	- 1	confidentiality of his or her personal and clinical records.	and		regident 1	ity does ensure that	the	
	ĺ	records,	ar		resident h	as the right to perce	mal	
	1	Personal privacy includes accommodations,	1		privacy ar	o confidentiality of	fhic o-	
		medical treatment, written and telephone			ner berson	lal and clinical reco	ud-	
			1	- 1	All resider	nts have the potenti	al to be	
			:	- -	anceieu.			1. 1
	r	does not require the facility to provide a private room for each resident.			All license	d nursing staff will	be in-	
	ļ	Today,		- 1	serviced of	1 3/23/11 by the DC	77.5	1
	Į E	ection, the resident may appear (e)(3) of this		- 1	regarding b	(eeping the clinical		1
	i s	ection, the resident may approve or refuse the			records clo	sed when not in use		
	Jin	elease of personal and clinical records to any advidual outside the facility.		1.	Daily rando	om monitoring will	h.	- 1
	1	Total do the racility.	1	- 1 '	TOTIC DA LUG	DUN or her decim	222	
	7	he resident's right to refuse release of personal	.	1	Audits Will	Occur five times no		- 1
	re	nd clinical records does not apply when the sident is transferred to exact the sident is the sident is transferred to exact the sident is the		1,	veek times	tour weeks than	1-1	
		sident is transferred to another health care stitution; or record release is required by law.	1	10.0	o cusule co	mpliance The room	14. 0	
				,	audits	Will be reported to	41	*1
	11	le facility must keep confidential all information	1	1	A Commi	tee quarterly by the		1
	the	ntained in the resident's records, regardless of		1 1	ON. The	JA Committee *-: 11		1
	rek	ease is required by transfer to		110	lake recom	mendations and dev	relon	1
	7.1	MIN IVOIC II ISULUTION BOAR Phied made.	1	l ai	r action pla	II II areas of		1
	cor	tract; or the resident.		no	oncomplian	ce are noted. The	04	- 1
			1	10	omminitee n	neets quarterly and	38	- 1
	This	s REQUIREMENT is not met as evidenced	1	CO	usists of th	e Administrator De	ON	- 1
				175	SISTAIL DO	N. MDS Coordinat	-	1
	Bat	sed on observation and interview the facility		TAT	cuical Dire	ctor Social Samian	_	
				AC	uvity Dire	ctor. Business Office		1
		ord for one (#13) of twenty-three residents		Ma	nager and	others as indicated.	.6	
	İ							· .
			1		62			

	7/2011 14:33 8	8655945739	HE	ALTH CARE FA	CILITY	PAGE	09/42
DEPA	RTMENT OF HEALTH	AND HUMAN SERVICES	_				20 CANADACO DA PARA
OFIAIL	-US LOK WEDICARE	& MEDICAID SERVICES			· · ·	FOR	D: 05/16/2011 M APPROVED
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2)	MULTIPLE CONSTRI	UCTION	(X3) DATE	O. 0938-0391
		445383	B. W				
NAME OF	PROVIDER OR SUPPLIER					05/	12/2011
		CENTER NURSING HOME		1001 MCARTH	S, CITY, STATE, ZIP CODE UR DRIVE ER, TN 37355	I .	322011
(X4) ID PREFIX	SUMMARY STAT	EMENT OF DEFICIENCIES	1 10				
TAG		MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	PREF		OVIDER'S PLAN OF CORRI CORRECTIVE ACTION SH REFERENCED TO THE AP DEFICIENCY)		COMPLETION DATE
F 164	Continued From page The findings included	e 4 I:	F 1	64		- 	
	preparing medications. Observation revealed medications, the Med Record (MAR) was let cart, with the page unname and medication passing by the medication	after RN #1 prepared the ication Administration it on top of the medication covered, with the resident list in sight of anyone ition cart.	s				
F 167 4 SS=C F	the clinical record was 183.10(g)(1) RIGHT TO READILY ACCESSIBL	O SURVEY RESULTS -	F 16	7 F167			االقاعا
F	ederal or State survey prrection in effect with	respect to the facility.	y	available for in a place rea	does make the resu examination and d adily accessible to r	nes nost	
ac		the results available for ost in a place readily and must post a notice of		availability. All residents affected. The binder w	t a notice of their have the potential t ith the survey resul	ts was	
Ba fail the rea	ased on observation at ed to post a notice ind most recent State sur dily accessible to resk a findings included:	nd interview the facility icating the availability of		a notice of the by the Mainte The residents where the sur- during the res 5/24/11 by the The Administ	accessible to reside ir availability on 5 mance Supervisor. will also be made a vey results can be lident council meeting Activity Director. rator or her designe cessibility of the su	ents with /10/11 aware of ocated ng on	

O.E.	DANTIBLE	0000340735	He	LAL I	H CARE FAC	ILITY	P4	AGE 10/4	2
STAT	EMENT OF DESIGNATION	TH AND HUMAN SERVICES RE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA					F	TED: 05/16	OVE
AND	LAN OF CORRECTION	IDENTIFICATION NUMBER:	1,,,,,	MUL:	TIPLE CONSTRU NG	CTION	(X3) DA	NO. 0938	-039·
- No. 10		445383	B. W	ING_					
	OF PROVIDER OR SUPPLIE			107	966			05/12/2011	
UNI (X4)		AL CENTER NURSING HOME		1	1001 MCARTHU MANCHESTE	CITY, STATE, ZIP COI R DRIVE	DE		
	FIX (EACH OFFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG	ΉX	PROV	IDER'S PLAN OF COR CORRECTIVE ACTION OF FERENCED TO THE A DEFICIENCY)		OOMPLE DATE) TION
F 1	167 Continued From p	page 5	F	167	results by				
	survey were located office in a white bit approximately five signage to indicate located inside the value of the beauty shop, reaware of where the State survey were located in the beauty shop, reaware of where the State survey were located in the source with resided 4:45 p.m., in the country in the facility's survey of the facility's survey of the state in the survey of the survey	May 10, 2011, at 9:00 a.m., #15, #16, #17, and #18), in vealed the residents were no results of the most recent ocated. ent #11 on May 11, 2011, at urtyard, revealed the resident of the location of the posting desults.	t		will occur if four weeks compliance will be repo quarterly by Committee and develop noncompliar Committee if of the Admit DON, MDS Director, Soo	andom questioni of ensure compliant five times per we then weekly to e The results of a rted to the QA C the Administrat will make recom an action plan if nce are noted. The neets quarterly a nistrator, DON, A Coordinator, Me cial Services, Act siness Office Ma icated.	nce. Audits set times sensure these audit committee or. The Q mendation f areas of the QA and consists Assistant dical	S A S	
= 241 SS=D	results of the most re located outside the A white binder, inside a approximately five fer observation and inter- signage to indicate the located inside the whi- survey results were no requiring a wheelchair 483.15(a) DIGNITY A	et off the floor. Continued view confirmed there was no e survey results were te binder, and confirmed the ot accessible to residents		F	241	i.		63111	
312	more and in an env	ote care for residents in a ronment that maintains or nt's dignity and respect in r her individuality.		16	sidents in a	does promote ca manner and in that maintains o	an		

environment that maintains or

05/17/2011 14:33 8655945/39

HEALTH CARE FACILITY

PAGE 11/42

DEPARTMENT OF HEALTH AND HUMAN SERVICES

011 /ED 391

STATEME	ENTERS FOR MEDICARE & MEDICAID SERVICES ITEMENT OF DEFICIENCIES (X1) PROVIDER IS NO.				PRINTED: 05/16/20 FORM APPROV		
	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI, A. BUIL		JETION	(X3) DATE COMPI	<u>0. 0938-03</u> Survey
NAME OF	PROVIDER OR SUPPLIER	445383	B. WING	·		18	
		L CENTER NURSING HOME	15	INDI MCWKIH	CITY, STATE, ZIP CODE	05/	12/2011
(X4) ID PREFIX TAG	SUMMARY ST. (EACH DEFICIENC REGULATORY OR I	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		VIDER'S PLAN OF CORRECT CORRECTIVE ACTION SHOULEFERENCED TO THE APPROPRIES		COMPLETIO DATE
F 241	Continued From pa		F 24	enhances	each resident's dien	nity and	DATE
In M M pn Ot on (re	Based on medical is and interview, the fa for three (#2, #3, #1 residents reviewed. The findings included Resident #2 was address. The findings included Resident Pulmonal Observation on May 10 aintenance Director, aintenance Director ior to entering the resident resident included Resident R	nitted to the facility on April pses including Urinary Tract order, and Chronic ry Disease. 10, 2011, at 1:55 p.m., iying on the bed. Further the Maintenance Director room without knocking. 2011, at 1:55 p.m., with the in the hall, confirmed the failed to knock on the door sident's room.		her individed All resident affected. All facility on dignity resident's This will in before enter The DON or responsible random obstrooms. Audit per week the weekly to ear results of the reported to the quarterly by Committee or recommendation plan in compliant Committee in the committee of the results of the recommendation plan in compliant Committee in the committee of the recommendation plan in the committee of the results of the recommendation plan in the committee of the recommendation plan in the committee of the recommendation plan in the recommend	full recognition of duality. Into have the potention of staff will be in-ser and respect of all by the DON on 5/2: Include knocking on the designee will be for monitoring by servation of staff endits will occur five the servation of staff endits will be the QA Committee the DON. The QA will make attons and develop a fareas of the servation. The contest quarterly and the servation of the serv	his or al to be viced 5/11. doors be ttering imes n The	
inte 201 con	erview with the Direct	tor of Nursing on May 12, e administrator's office, nock before entering the	N A	Assistant DO Medical Dire Activity Dire	e Administrator, D N, MDS Coordinate ector, Social Service ctor, Business Office others as indicated	tor,	

05/17/2011 14:33 8655945,39 HEALTH CARE FACILTI

A BUILI B, WING	TREET ADDRESS 1001 MCARTH MANCHESTE PROCECEACH CROSS-F	OUCTION (X3	
A BUILI B, WING S ID PREFIX TAG	DING STREET ADDRESS 1001 MCARTH MANCHESTE PRO (EACH CROSS-F	S, CITY, STATE, ZIP CODE UR DRIVE R, TN 37355 WIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD I	MB NO. 0938 DATE SURVEY COMPLETED
A BUILI B, WING S ID PREFIX TAG	DING STREET ADDRESS 1001 MCARTH MANCHESTE PRO (EACH CROSS-F	S, CITY, STATE, ZIP CODE UR DRIVE R, TN 37355 WIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD I	OS/12/2011
B, WING	TREET ADDRESS 1001 MCARTH MANCHESTE PROCECEACH CROSS-F	UR DRIVE R, TN 37355 VIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD I	05/12/2011
ID PREFIX TAG	TREET ADDRESS 1001 MCARTH MANCHESTE PRO (EACH CROSS-F	UR DRIVE R, TN 37355 VIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD I	1 00
ID PREFIX TAG	MANCHESTE PRO (EACH CROSS-F	UR DRIVE R, TN 37355 VIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD I	1 00
PREFIX TAG	PRO (EACH CROSS-F	VIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD I	
PREFIX TAG	CROSS	REFERENCED TO THE APPROPRIE	
F 24	1		
	•		
	N 6.0		
F 253	F253 -		
, 200	1233		6311
i	housekeepin necessary to orderly, and	g and maintenance servic maintain a sanitary, comfortable interior	
1	All residents	have the potential to be	1
	room was cle nousekeeping	aned on 5/10/11 by	-
1 '	vas repaired	on 5/11/11	
, v	viii de in-serv	riced by 6/3/11 regarding	
h	ousekeeping faintenance v	g of bathrooms by the supervisor.	
T	toper upkeep he Administr	of gerichairs. ator or her designee wil	
	v p h N 6. pr	housekeepin necessary to orderly, and All residents affected. The commod room was cle housekeeping The gerichair was repaired all nursing howill be in-serv proper cleanin housekeeping Maintenance v 6/3/11 by the aproper upkeep The Administr	This facility does provide housekeeping and maintenance service necessary to maintain a sanitary, orderly, and comfortable interior. All residents have the potential to be

#579 P.003/003

05/17/2011 14:33 8655945,39

HEALTH CARE FACILITY

PAGE 13/42

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

A BUILDING

(X2) MULTIPLE CONSTRUCTION

A BUILDING

(X3) DATE SURVEY COMPLETED

		IDENTIFICATION NUMBER:	A BUILD	LTIPLE CONSTRUCTION	(X3) DA	TE SURVEY
Name :		445383	B. WING		- "	··· CETEU
	PROVIDER OR SUPPLIER					5/12/2011
(X4) 10 PREFIX	C. In make a series	CENTER NURSING HOME		TREET ADDRESS, CITY, STATE, 1001 MCARTHUR DRIVE MANCHESTER, TN 37355	ZIP CODE	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	PREFIX TAG	random observation of regarding cleanliness of also equipment uplease	of the facility	COMPLETE
= 280 At SS=D Tind Index in the legal and	Observation on May resident #22's room, sitting in a gerichair. revealed both arms of material of the chair with the resident has the mompetent or otherwich the competent or otherwich the competent or otherwich the chair with the chair with the chair with the comprehensive care with the comprehensive assess and sciplinary team, to resident, and other chair the chair with the resident, and other chair the chair as a determined, to the extent practical, a registered in the resident, the resident, and other chair the chair	med a dried brown substance at. 10, 2011, at 8:25 a.m., of revealed the resident was Continued observation of the chair were torn, the was cracked and unraveled. 3 (certified nursing assistant) 3:35 a.m., in the hallway, as in need of repair. (x)(2) RIGHT TO NING CARE-REVISE CP ight, unless adjudged ise found to be a laws of the State, to care and treatment or eatment.	F 280	occur five times per we	o. Audits will eek times four ensure ts of these audits QA Committee The QA ecommendations old if areas of ed. The QA erly and consists ON, Assistant r, Medical s, Activity the Manager and et that a is developed completion of the ent. Itential to be times per eting by the MDS entry the modern of the entry the entry the modern of the entry the e	

05/17/2011 14:33 8655945/39

HEALTH CARE FACILITY

PAGE 14/42

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/16/2011

SIMIENSE	VI (JE DEEDCEMOJEC	(X1) PROVIDER/SUPPLIER/CLIA			FOR OMB N	M APPROVE 0. 0938-039
NO PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BUILDING		SURVEY LETED
WALAR OF		445383	B. WING			
	PROVIDER OR SUPPLIER		91	PEET APPREAS ACTIVITIES	05/	12/2011
		L CENTER NURSING HOME	1	TREET ADDRESS, CITY, STATE, 1001 MCARTHUR DRIVE MANCHESTER, TN 37355	20	
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	(D			
TAG	REGULATORY OR	T MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	THE APPROPRIATE	COMPLETION DATE
F 280	Continued From pa	age 9	F 280	serviced on 5/25/11 b	y the DON	
	This REQUIREMEN	NT is not met as evidenced		regarding not leaving	recident #12	
1				unattended until trans	fer is complete	
	Based on medical	record review, observation,		when the resident has	requested to be	
				put in bed.		
	residents reviewed.			Audits will occur 5 tin	ies per	
i			1 1	week by the DON or I	er designee to	
	The findings include	ed:	1 1	ensure compliance wit	h care plan	
- 1				updates and alarm fun	ctionality.	
	resident #10 was a	dmitted to the facility on April	1 1	Random observation w	vill be done	
				regarding resident #12	to ensure	
1	lemiparesis.	Accident) with Right Side		compliance.		1
1.				Audits will occur five	imes per week	1
į N	Medical record review	w of a fall risk assessment		times four week and the	en weekly to	
1 3	igh risk for falls.	evealed the resident was at		ensure compliance. Th	e results of these	J
1	S. Frenches		- 1	audits will be reported	to the QA	
R	eview of a facility in	vestigation dated April 24,		Committee quarterly.	The QA	- 1
				Committee will make re	commendations	1
				and develop an action p	lan if areas of	- 1
				noncompliance are note	d. The QA	1
		dy/bed alarm, was it in m sounding? No" (no		Committee meets quarte	erly and consists	
inj	ury)	m scanding r No," (no	1	of the Administrator, DON, MDS Coordinator	ON, Assistant	
1	NAT OF		1 1	Director, Social Services	r, Medical	- 1
Me	cical record review	of the Care Plan dated	1 1	Director and others as in	s, Activity	- 1
7.40	d alarm.	ed no documentation of the		others as in	dicated.	- 1
Ob	servation on May 1;	2, 2011, at 7:00 a.m.,	1	,	*	
			1			
100	ment a still. Obser	vation on May 12, 2011, at int's room, revealed a			1 .	
	ssure pad alarm on	DIS MOM POMONIA -			1	1
1		reducits ped.				
			- 1	- T-		- 1

HEALTH CARE FACILITY

PAGE 15/42

CENT	ERS FOR MEDICAR	TH AND HUMAN SERVICES RE & MEDICAID SERVICES			ěš		PRINTE	0: 05/16/20
ND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIES	Torn	Mussa -			FOR	M APPROV 0. 0938-03
		IDENTIFICATION NUMBER:	A. B	MULTIPLE UILDING	CONSTR	UCTION	(X3) DATE	SURVEY
MME OF	PROVIDER OR SUPPLIER	445383	B, W	/ING]	
UNITED	REGIONAL MEDICA	L CENTER NURSING HOME		1001	MI COOKE ! IL	S, CITY, STATE, ZIP CODE UR DRIVE	05/1	12/2011
(X4) ID PREFIX TAG	SUMMARY ST. (EACH DEFICIENC REGULATORY OR I	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREI TAC	FIX	PRO	R, TN 37355 OVIDER'S PLAN OF CORRECTIVE ACTION SHOREFERENCED TO THE APP		(XG) COMPLETION DATE
	confirmed the Care include the bed alar Resident #12 was a February 18, 2011, Contusion of the Kontucky	2, 2011, at 7:25 a.m., with the ursing), in the DON's office,	F	280		DEFICIENCY		
i fi a a c c t t t t t t t t t c c c c c c c	Medical record review and April 4, 2011, revexperienced falls after ransfers and being to ansfers was being some nursing notes and ated February 25, 20 evealed the resident.	w of the nursing notes and			i v	·		
ad		of the Care Plan reviewed ealed no intervention to need to be attended if ed.						
imp and revi atte	rsing's office, revealed	ent Care Plan was not						
1 483	.20(k)(3)(i) SERVICE DFESSIONAL STAN	ES PROVIDED MEET DARDS	F 281					
						1	- 1	

8655945739

HEALTH CARE FACILITY

PAGE 16/42

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 05/16/2011 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING B. WING 445383 NAME OF PROVIDER OR SUPPLIER 05/12/2011 STREET ADDRESS, CITY, STATE, ZIP CODE UNITED REGIONAL MEDICAL CENTER NURSING HOME 1001 MCARTHUR DRIVE MANCHESTER, TN 37255 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X5) COMPLETION TAG TAG DATE DEFICIENCY) F 281 Continued From page 11 F281 F 281 6/3/11 The services provided or arranged by the facility must meet professional standards of quality. This facility does ensure that the services provided or arranged by the facility meet professional standards of This REQUIREMENT is not met as evidenced quality. by: All residents have the potential to be Based on medical record review, observation, and interview, the facility failed to follow the affected. physician's orders for one (#1) of twenty-three Written communication was sent to dietary on 5/11/11 by nursing staff resident's reviewed. regarding resident #1. The tray card for The findings included: resident # 1 was corrected as of 5/11/11 by the Dietary Manager ensuring that Resident #1 was admitted to the facility on August 17, 2007, and readmitted on April 11, 2011, with the appropriate items are sent each meal. diagnoses including Pneumonia, Failure to All Dietary staff will be in-serviced by Thrive, Fractured Tibia, Hypertension, Chronic 5/25/11 regarding ensuring all residents Obstructive Pulmonary Disease, Congestive receive the correct items on their tray. Heart Failure, Osteoporosis, Generalized Anxiety, Audits will occur 5 times per week by and Depressive Disorder. the Dietary Manager or his designee Medical record review of the physician's ongoing to ensure compliance. The recapitulation orders dated May 2011, revealed results of these audits will be reported to the resident was to receive a magic cup the QA Committee quarterly. The QA (nutritional supplement with additional calories) Committee will make recommendations with meals, three times a day. and develop an action plan if areas of

FORM CMS-2567(02-99) Previous Versions Obsolete

the resident's breakfast tray.

Observation on May 10, 2011, at 8:16 a.m.,

revealed Certified Nursing Assistant (CNA)

magic cup on the resident's breakfast tray.

Observation on May 11, 2011, at 7:10 a.m., revealed a CNA assisting the resident with the

assisting the resident with the breakfast meal.

Continued observation revealed there was no

breakfast meal, and there was no magic cup on

Event ID: QZPF11

Facility ID: TN1601

noncompliance are noted. The QA

Committee meets quarterly and consists

of the Administrator, DON, Assistant

Administrator, MDS Coordinator,

Medical Director, Social Services, Activity Director, Dietary Manger and

others as indicated.

If continuation sheet Page 12 of 32

HEALTH CARE FACILITY

PAGE 17/42

DEPARTMENT (OF HEALTH	AND HIMAN	SERVICES
CENTERS FOR	14ED101	THE PROPERTY	OFKAICE?
ULIVI EKO PUK	MEDICARE	E MEDICAID	

PRINTED: 05/16/2011

STATEME	ERS FOR MEDICAL NT OF DEFICIENCIES	RE & MEDICAID SERVICES	<u> </u>			FOR	RM APPROVE
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI	ULTIPLE CONSTRU	JCTION	(X3) DAT	O. 0938-039 E SURVEY PLETED
		445383	B. WIN	G	1		
	PROVIDER OR SUPPLIES			-		05	/12/2011
UNITED		AL CENTER NURSING HOME	ľ	1001 MCARTH	S, CITY, STATE, ZIP CODE		
(X4) ID PREFIX	(4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL FAG REGULATORY OF LIST INC.		ID		R, TN 37355		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	PREFIX		OVIDER'S PLAN OF CORRECT CORRECTIVE ACTION SHO REFERENCED TO THE APPR DEFICIENCY)		COMPLETION DATE
F 281	Continued From p	age 12	F 28	11			
F 315 \$\$=D	resident's room, co cup provided with t confirmed the phys followed.	terview on May 11, 2011, at Director of Nursing, in the infirmed there was no magic he breakfast meal, and ician's orders were not HETER, PREVENT UTI, ER	F 316	F315	,		ا الالما
i c v ti	resident who enters indwelling catheter is resident's clinical contact was latheterization was latheterization and service the teatment and service at the service that the serv	ent's comprehensive cility must ensure that a the facility without an sont catheterized unless the notition demonstrates that necessary; and a resident bladder receives appropriate set to prevent urinary tract tore as much normal bladder		resident entindwelling catheterized condition de catheterizat resident where ceives apparent apparent ceives apparent ceives to present ceives to present ceives apparent ceives to present ceives apparent ce	y does ensure that where the facility without the facility without the resident dunless his/her clinic emonstrates that ion was necessary. At ionis incontinent of blad propriate treatment and prevent urinary tract	ut an is not al also, a adder	
Exports for the Res. (City He	sased on medical re plicy, observation, and iled to establish and ir one (#10) of twent as findings included: asident #10 was adm 2011, with diagnose erebral Vascular Admiparesis.	nitted to the facility on April s including Acute CVA cident) with Right Side		Resident # 1 & Bladder p. MDS Coordi and Tech we on 5/24/11 re communicati & bladder pr were in-servi Director of N and procedure for the bowel	nd to restore as much ction as possible. O was placed on the I rogram on 5/12/11. I inator, Restorative Nure in-serviced by the egarding proper on in relation to the bogram. All direct care ced on 5/25/11 by the fursing regarding the es for proper monitor & bladder program.	Bowel The Irse DON Dowel e staff e policy ing	
dat	dical record review ed April 11, 2011, re	of the Minimum Data Set		Monitoring w	vill occur five times p	er	

HEALTH CARE FACILITY

DEPARTMENT OF HEALTH AND HUMAN SERVICES PAGE 18/42 CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 05/16/2011 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION FORM APPROVED (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A BUILDING COMPLETED 445383 B, WING NAME OF PROVIDER OR SUPPLIER 05/12/2011 UNITED REGIONAL MEDICAL CENTER NURSING HOME STREET ADDRESS, CITY, STATE, ZIP CODE 1001 MCARTHUR DRIVE SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION) MANCHESTER, TN 37355 (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG ID PREFIX COMPLETION DATE TAG DEFICIENCY) Continued From page 13 F 315 week times four weeks then weekly frequently incontinent of bladder. F 315 times four weeks, and then random to ensure compliance by the DON or her Medical record review of the Bowel and Bladder Training Assessment dated April 12, 2011, designee. The results of these audits revealed the resident was a candidate for toileting will be reported to the QA Committee (timed voiding), quarterly by the Director of Nursing. The QA Committee will make Review of facility policy, Types of Bowel and recommendations and develop an action Bladder Restorative Programs revealed plan if areas of noncompliance are "...Maintenance Program These residents either noted. The QA Committee consists of lack the cognitive ability to independently perform elimination functions or lack the physical the Administrator, DON, Assistant control... There will be some residents who have a DON, MDS Coordinator, Medical low probability of responding and the objective is Director, Social Services, Activity to determine their voiding pattern...and assure the Director and others as indicated. staff assist or remind them to void prior to expected episodes of incontinence... Observation on May 12, 2011, at 7:00 a.m., revealed the resident seated in a wheelchair in the dining area. Interview on May 12, 2011, at 10:05 a.m., with the Assistant Director of Nursing, in the Director of Nursing office, confirmed an individualized toileting plan had not been established for the resident. F 323 483.25(h) FREE OF ACCIDENT SSEG HAZARDS/SUPERVISION/DEVICES F323 F 323 43/11 The facility must ensure that the resident This facility does ensure that ensure that environment remains as free of accident hazards the resident environment remains as free as is possible; and each resident receives of accident hazards as is possible; and adequate supervision and assistance devices to each resident receives adequate prevent accidents. supervision and assistance devices to prevent accidents. All residents have the potential to be

affected.

05/17/2011 14:33 865594...39

HEALTH CARE FACILI..

PAGE 19/42

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 05/16/2011

CENTERS FOR MEDICAR	E & MEDICAID SERVICES	55	FORM APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445383	MULTIPLE CONSTRUCTION ULDING	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER			05/12/2011
UNITED REGIONAL MEDICA	L CENTER NURSING HOME	STREET ADDRESS, CITY, STATE, Z	IP CODE

VAME OF	PROVIDER OR SUPPLIER		1-			05/1	2/2011	
UNITED	REGIONAL MEDICAL CENTER NURSING HOME		, 1	REET ADDRESS, CITY, ST 1001 MCARTHUR DRIVE MANCHESTER, TN 3	SS, CITY, STATE, ZIP CODE HUR DRIVE			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S F (EACH CORRECT CROSS-REFERENCE	PLAN OF CORRECT		COMPLET DATE	
Ma da a straight and the straight ass	This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility documentation, observation, and interview, the facility failed to ensure adequate supervision while toileting for one resident (#1), failed to ensure adequate supervision for one resident (#4), failed to ensure safety device was functioning for one resident (#10) of twenty-three residents reviewed, and failed to ensure a safe enviornment for one shower room of two shower rooms observed. The facility's failure caused actual harm to resident #1. The findings included: Resident #1 was admitted to the facility on August 17, 2007, and readmitted on April 11, 2011, with diagnoses including Pneumonia, Failure to Thrive, Fractured Tibia, Hypertension, Chronic Obstructive Pulmonary Disease, Congestive deart Failure, Osteoporosis, Generalized Anxiety, and Depressive Disorder. Idedical record review of the Minimum Data Set acted December 16, 2010, revealed the following: score of ten on the Brief Interview for Mental tatus (BIMS) indicating the resident had oderately impaired cognitive skills; was totally ependent for transfers, toilet use, and personal giene; did not walk; was not steady and only able to stabilize with human assistance moving on seated to standing position; and was not seady and only able to stabilize with human sistance moving on and off the toilet.		i i i r ffi A m w im M w tir en res	Resident #1's incidents. Staff will be in-ser regarding the proper wheelchair or a gas when on BSC of serious the DON with no a incidents. Staff will be in-ser regarding the proper transferring this reserviced on 5/25/egarding the monitous will be in-serviced on 5/25/egarding the monitous will be incoming meeting five incidents will be incoming meeting five incidents will be incoming meeting five incidents will occur week times four weeks, and sure compliance by sults of these audits incidents of these audits incidents of these audits of the sector of Nursing.	or. Staff were positioning of ons on 4/28/11 nt. ident was revial political	by the sewed on buddy as up in sed 9/11 by on to 11 ft when will be N s seek s. eer by to the buddy as up in sed 19/11 tion will be N s		

FORM CMS-2567(02-99) Pravious Versions Obsolete

Event ID: QZPF11

Facility ID: TN1601

If continuation sheet Page 15 of 32

8655945739

HEALTH CARE FACILITY

PAGE 20/42

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICE

PRINTED: 05/16/2011

STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1	<u> </u>		OMB NO	0. 0938-039
MNU PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD		ICTION	(X3) DATE S	SURVEY
WALES 0		445383	B. WING			385	
	PROVIDER OR SUPPLIER REGIONAL MEDICA	L CENTER NURSING HOME	1	1001 MCARTH		05/*	12/2011
(X4) ID PREFIX TAG		TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PRO	R, TN 37355 MDER'S PLAN OF CORRECT CORRECTIVE ACTION SHOT REFERENCED TO THE APPR DEFICIENCY)		COMPLETION DATE
Me second Me recomment metures me second me se	Medical record review con December 28, 2 falls r/t (related to). balancehx (histor resident for signs of chair" Medical record review condition Change of seat, reside mall abrasion on (Land) dressed" Medical record review condition Change of time noted, reveausistant) had reside of the condition Change of time noted, reveausistant) had reside of the condition Change of time noted, reveausingteeth (dentified slid off BSC to find the condition change of the condition ch	ptember 22, 2010, revealed the in risk for falls. It is for falls	F 323	noncompl Committee Administra MDS Cook	e will make recomme op an action plan if ar iance are noted. The consists of the ator, DON, Assistant dinator, Medical Directors. Activity Directors	eas of QA DON,	

HEALTH CARE FACILITY

, PAGE 21/42

CENTE	ERS FOR MEDICAR	H AND HUMAN SERVICES				PRINTEL	D: 05/16/201
SIATEMEN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	7		·	OMB NO	0.0938-039
AND PLAN	ME OF PROVIDER OR SUPPLIER	IDENTIFICATION NUMBER:	A. BUILDING	PLE CONSTRU	CTION	(X3) DATE (SURVEY
NAME OF		445383	B. WING_				
			l eres	ET ADODEDO		05/1	12/2011
UNITED	REGIONAL MEDICA	L CENTER NURSING HOME	10	01 MCARTHL	, CITY, STATE, ZIP COD IR DRIVE R, TN 37355	Æ	
(X4) ID PREFIX	SUMMARY ST	ATEMENT OF DEFICIENCIES	I D		2 - 4 g - 1 g - 5 - 50 kG 1 kB 2 C T T		
ĐẠT		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(CACH	VIDER'S PLAN OF CORI CORRECTIVE ACTION S EFERENCED TO THE A DEFICIENCY)	SHOULD DO	COMPLETION DATE
F 323	Continued From pa	nge 16		3.000			
. .	own bed without av cheek and stitches	vakening Cutte (1) (1-a)	F 323	•			
	Medical record review	ew of a nursing note dated	*			78	
		Z. TU D. m. revested "					
	(ABBAIL (PLEACE UITS)	I noted a lot of herial					
j	eyes and area arou	nd. Noted cut to left cheek"			347		
	Observation on May	9, 2011, at 1:40 p.m.,	1				
	revealed the resider the bed.	nt seated in a recliner beside				1	
1	ine ocu,	00.00 99.20000000000				1	
	Interview on May 10	, 2011, at 3:25 p.m., with the				1	- 1
						ľ	
.	observation when on	esident required line of sight the commode.					
1	nterview on May 11,	2011, at 2:45 p.m, with					ŀ
			1				
		office, revealed on January d placed the resident in the	-				
							1
							- 1
Č	NA #3 left the reside	inued interview revealed				}	
, ,,		O OPTOID the annint			ē		- 1
						1	- 1
111	ALL RICE MILERICUSIE VI	nto the commode. ith CNA #3 revealed while				1	
1 444	DIE GOOIWAY IN FAMI	IDST DOCIOLORUS II.				1	1
110	Pivelli liau uniockea	IDO Whoolehain basi					
the	resident had fallen	onto the flags. On the flags					
1 1114	CLAIGAN ANTHI CHAN WEST	COntinuad No					
Will	attended at the time	of the fall on January 24,					
20	11.	, -,,	1				1
Inte	erview on May 11, 20	011, at 3:00 p.m., with					

05/17/2011 14:33 8655940.39

HEALTH CARE FACILI ..

PAGE 22/42

STATEMEN	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION TO THE MEDICAL PROPERTY CLIP TO					FORM	0: 05/16/201 MAPPROVE 0: 0938-039
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	LTIPLE CONSTRU XNG	CTION	(X3) DATE :	SURVEY
NAME OF		445383	B. WING				
l'	PROVIDER OR SUPPLIED	AL CENTER NURSING HOME	- 1	1001 MCARTHI		05/	12/2011
(X4) ID PREFIX TAG	PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG		MOER'S PLAN OF CORRECTIVE ACTION SHO EFERENCED TO THE APPL DEFICIENCY)		COMPLETION DATE
Model Market Mar	2011, CNA #4 had bedside commode while the resident was resident, and was resident, and was resident, and was resident, and was resident was so dentures at the sinil Continued interview the resident was so continued interview see the resident at Resident #4 was advermber 9, 2005, an July 9, 2010, with congestive Heart Facet at Continued interview at ledical record review at persons physical edical record review as persons physical assist for training assistance with the sident record review and continued in the persons physical assist for training assistant was removed the facility in the person of	ministrator's office, with the ent, revealed on March 5, placed the resident on the Continued interview revealed was seated on the bedside had turned away from the washing the resident's k at the time of the fall. It is revealed CNA #4 was aware metimes dizzy and unsteady. It confirmed CNA #4 could not the time of the fall. In itted to the facility on and readmitted to the facility on and readmitted to the facility on and readmitted to the facility in diagnoses including ailure, Lymphedema Bilateral and Diabetes. In of the MDS (Minimum Data ensive assistance with two assist for transfers. In of the MDS dated January eresident required with two plus persons insfers. In of the fall risk assessment is,	F 323				

HEALTH CARE FACILITY

PAGE 23/42

DEPA	RTMENT OF HEAL	TH AND HUMAN SERVICES	ILA	LIN CARE FA	CILITY	PAGI	E 23/42
	ERS FOR MEDICAL	RE & MEDICAID SERVICES				FOR	0: 05/16/201 M APPROVE
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MU A. BUILO	LTIPLE CONSTRU	CTION	(X3) DATE	<u>0. 0938-039</u>
None on		445383	B. WING				
	PROVIDER OR SUPPLIER			TREET ADDRESS		05/	12/2011
(X4) ID		L CENTER NURSING HOME		1001 MCARTHU MANCHESTEI	CITY, STATE, ZIP COD R DRIVE	E	
PREFIX TAG	(EACH DEFICIENC REGULATORY OR	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PRO	IDER'S PLAN OF CORR CORRECTIVE ACTION S FERENCED TO THE AF DEFICIENCY)		COMPLETION DATE
final with the contract of the	(adequate) help to a (related to) obesity, unsteady gait (with) (no injury)." Review of the facility 10, 2011, revealed, to bed, resident stand (resident) to floorS or 2 person transfer. Review of the facility 5, 2011, revealed ". esident from bed to sident from bed to sist (and) did not uniforStaff advised by ant lift is to be used (ansferring this resident terview on May 10, 20N, in the DON's off is stance or the lift was falls on December 11, and March 15, 2011, with diagnoses are bral Vascular Accomparesis.	A held (resident) (and) let staff educated to ensure adq support/transfer resident (decreased) strength (and) amb (ambulation)/transfer y investigation dated February "CNA was putting resident ted going down CNA slid staff educated either to use lift for any transfer(no injury)." investigation dated Marchtech attempted to transfer w/c (wheelchair) (without) see lift. (Patient) fell in front of DON (Director of Nursing) (at) all times when ent(no injury)." 2011, at 9:45 a.m., with the fice, confirmed two person ras not used at the time of 26, 2010, February 10, 2011. ditted to the facility on April is including Acute CVA cident) with Right Side	F 323	 	OLTIVIENCY)		

8655945739

HEALTH CARE FACILITY

PAGE 24/42

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 05/16/2011 FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A BUILDING COMPLETED

OMB NO. 0938-0391 445383 B. WING NAME OF PROVIDER OR SUPPLIER 05/12/2011 STREET ADDRESS, CITY, STATE, ZIP CODE UNITED REGIONAL MEDICAL CENTER NURSING HOME 1001 MCARTHUR DRIVE MANCHESTER, TN 37355 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG PREFIX COMPLETION DATE DEFICIENCY) F 323 Continued From page 19 F 323 Medical record review of the fall risk assessment dated April 5, 2011, revealed the resident was at high risk for falls. Review of the facility investigation dated April 24, 2011, revealed, "... Resident putting self back to bed (after) putting self on bedside commode (without) assist. Resident fell down to...knees...If the resident has a body/bed alarm, was it in place? Yes...Was alarm sounding? No..." (no injury) Interview on May 12, 2011, at 7:25 a.m., with the DON (Director of Nursing), in the DON's office, confirmed the safety device was not functioning at the time of the fail on April 24, 2011. Observation on May 10, 2011, at 1:45 p.m., of the 400 shower room, with the Maintenance Director, revealed a screw missing at the bottom of a comer strip of metal flashing. Further observation revealed the metal flashing protruding out at the bottom approximately 1/2 inch. Interview on May 10, 2011, at 1:45 p.m., with the Maintenance Director, in the 400 shower room, confirmed the screw was missing and the metal flashing was protruding at the bottom. 483.30(e) POSTED NURSE STAFFING F 356 F 356 INFORMATION SS=C F356 10/3/11 The facility must post the following information on This facility does post the following a daily basis: information on a daily basis: o Facility name. o The current date. Facility Name o The total number and the actual hours worked

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: QZPF11

Facility ID: TN1601

The current Date

If continuation sheet Page 20 of 32

05/17/2011 14:33 8655945739 HEALTH CARE FACILITY PAGE 25/42 DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 05/16/2011 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING 445383 B. WING NAME OF PROVIDER OR SUPPLIER 05/12/2011 STREET ADDRESS, CITY, STATE, ZIP CODE UNITED REGIONAL MEDICAL CENTER NURSING HOME 1001 MCARTHUR DRIVE MANCHESTER, TN 37355 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE ID PREFIX (X5) COMPLETION DATE TAG DEFICIENCY) F 356 Continued From page 20 F 356 The total number and the actual by the following categories of licensed and unlicensed nursing staff directly responsible for hours worked by the following resident care per shift: categories of licensed and unlicensed - Registered nurses. nursing staff directly responsible for Licensed practical nurses or licensed vocational nurses (as defined under State law). resident care per shift: Certified nurse aides. RN o Resident census. LPN The facility must post the nurse staffing data CNT specified above on a daily basis at the beginning Resident Census of each shift. Data must be posted as follows: All residents have the potential to be o Clear and readable format. affected. o in a prominent place readily accessible to The facility staffing information was residents and visitors. posted on 5/9/11 by the DON. The facility must, upon oral or written request, In-service was given by the make nurse staffing data available to the public Administrator to the DON and for review at a cost not to exceed the community Assistant DON on 6/1/11 regarding standard. the posting of the staffing The facility must maintain the posted daily nurse information on a daily basis. staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Monitoring will occur five times per week times to ensure compliance by the Administrator or her designee. This REQUIREMENT is not met as evidenced The results of these audits will be by: Based on observation and interview the facility reported to the QA Committee failed to post the nurse staffing data. quarterly by the Director of Nursing.

FORM CMS-2567(02-99) Previous Versions Obsolete

The findings included:

residents and visitors.

Observation on May 9, 2011, at 10:00 a.m.,

in a prominent place readily accessible to

revealed there was no nurse staffing data posted

Event ID: QZPF11

Fecility ID: TN1601

The QA Committee will make

action plan if areas of

Committee consists of the

Administrator, DON, Assistant

recommendations and develop an

noncompliance are noted. The QA

If continuation sheet Page 21 of 32

HEALTH CARE FACILITY

PAGE 26/42

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 05/16/2011

CENT	CENTERS FOR MEDICARE & MEDICAID S		0.53(5)(5)			FURI	M APPROVI	ĔĬ
AND PLAN	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A BUILD	TIPLE CONSTRUC	TION	(X3) DATE	O. 0938-03 SURVEY LETED	9
		445383	B. WING					
NAME OF	PROVIDER OR SUPPLIER		187	DEET ADDRESS	STR. 07400 4	05/	12/2011	
		CENTER NURSING HOME		1001 MCARTHU MANCHESTER				
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROV (EACH O	IDER'S PLAN OF CORRE ORRECTIVE ACTION SH FERENCED TO THE APP DEFICIENCY)	AH D DE	COMPLETION DATE	N
F 368	the Administrator's staffing data was no 483.35(f) FREQUE!	erview on May 9, 2011, at Director of Nursing, outside office, confirmed the nurse of posted. NCY OF MEALS/SNACKS A res and the facility provides a lity of regular times.	F 368	Director, S Director ar F368 This facility receives and three meals	OS Coordinator, Mocial Services, And others as indicated as does ensure each to the facility provided aily, at regular times.	activity ated. resident les at least	613111	
	There must be no me substantial evening of following day, except the facility must offer when a nourishing stup to 16 hours may evening meal and braitesident group agrees nourishing snack is set.	r snacks at bedtime daily. nack is provided at bedtime, lapse between a substantial rakfast the following day if a sto this meal span, and a erved.		comparable community. snacks at ber All residents affected. A new hydra offering of bimplemented Nurses were the Assistant will be in-ser the offering of documentatio	to normal mealtim. The facility must dtime daily. have the potential tion sheet that incledtime snacks was on 5/11/11 by the in-serviced at that DON. All nursing viced on 5/25/11 ref bedtime snacks an of this by the DO	to be udes the DON. time by staff egarding ind	•	
t d	ay. Based on interview with the state of the	is not met as evidenced th six residents (#14, #15, 1) the facility failed to offer y 10, 2011, at 9:00 a.m., 5, #16, #17, and #18), in led bedtime snacks were	t () . 1 . 1 . 1 . 1 . 1 . 1 . 1 . 1 . 1 .	Monitoring wat week times to DON or her dese audits worm tree quarring. The ecommendatilan if areas of the water of the commendatilan if areas of the water the water of the w	ill occur five times ensure compliance esignee. The resultill be reported to the arterly by the Dire QA Committee with one and develop are finoncompliance and Committee considerations.	s per e by the lts of the QA ctor of ill make n action		

8655945739

HEALTH CARE FACILITY

PAGE 27/42

DEPAR	RTMENT OF HEALT	H AND HUMAN SERVICES					PRINTE	D: 05/16/201
	NT OF DEFICIENCIES OF CORRECTION	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		MULT	IPLE CONSTRU	стюн	OMB N (X3) DATE	M APPROVE O. 0938-039
		445383	B. WI					LL IED
	PROVIDER OR SUPPLIER	CENTER NURSING HOME		STR	REET ADDRESS	CITY, STATE, ZIP CODE	05	12/2011
				M	001 MCARTHU IANCHESTEI	R DRIVE 2, TN 37355		
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PRON (EACH (/IDER'S PLAN OF CORRECT CORRECTIVE ACTION SHOU FERENCED TO THE APPRO DEFICIENCY)		COMPLETION DATE
F 368	Interview on May 11	ge 22 1, 2011, at 4:45 p.m., with courtyard revealed the ered a bedtime snack every	F3	168	Director, S	istrator, DON, Assist S Coordinator, Medio ocial Services, Activ d others as indicated	cal	
F 371 4	diabetic residents re nightly. Continued in revealed LPN #3 inst Assistants to offer so not eating well. Cont	tructed the Certified Nursing packs to residents who were tinued interview confirmed a not offered to all residents		1 F:	371			6 3111
(2 ur	uthorities; and 2) Store, prepare, dis nder sanitary condition			Fe sto un Al aff	proved or co ederal, State of ore, prepare, ider sanitary I residents have ceted. The thermowas replace on 5/9/11.	we the potential to be ometer in the walk in fr ed by the Dietary Mana	sources y I also od	
Ba fail fail	ased on observation	is not met as evidenced and interview the facility itary environment and er temperatures.		3.	Peaches we Manager on The walk in Maintenance The milk we cooler by the 5/9/11.	cooler was repaired by e Department on 5/11/ as properly stored in the e Dietary Manager on	y the	
Obs	servation on May 9, 2	2011, at 10:15 a.m., with	4	4.	The reach in /repaired by	cooler was checked the maintenance		

HEALTH CARE FACILITY

PAGE 28/42

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDIC

PRINTED: 05/16/2011 ED 91

A I WENT OF DEFICIENCIES		E & MEDICAID SERVICES	(V4) FDGI FD WE SEE SEE			FORM OMB NO		
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUC	TION	(X3) DATE S	SURVEY	
L		445383	B, WING			1		
NAME OF	PROVIDER OR SUPPLIER		1			05/1	2/2011	
		CENTER NURSING HOME	- 1	1001 MCARTHU MANCHESTER	CITY, STATE, ZIP CODE R DRIVE L TN 37355			
(X4) ID PREFIX TAG	(EACH DEFICIENC REGULATORY OR L	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG CROSS-REFERENCED DEFICI				CTION OULD BE PROPRIATE	COMPLETION DATE	
7. pr 8. ac 9. dr	the Certified Dietary the dietary department of the dietary department of the verify the temperature. The walk in refresize can of peaches (stored in an aluminor degrees F. (Fahrenh stored in a crate on the disposed of the hamble cheese in a five pound open opened and not dear to the cooking oil of the meat on the entire black of the disposed of the hamble cheese in a five pound open opened and not dear to the cooking oil of the meat on the entire black of the disposed of the hamble cheese in a five pound open opened and not dear to the cooking oil of the meat on the entire black of the disposed of the hamble cheese in a five pound of the meat slicer hamble cheese in a five pound of the meat on the entire black of the disposed of the hamble cheese in a five pound of the meat slicer hamble cheese in a five pound of the disposed of the hamble cheese in a five pound of the meat slicer hamble cheese in a five	Manager (CDM) present, in ent revealed the following: ezer revealed no thermometer ature. igerator had an institutional open and dated May 6, 2011, um can). er temperature was 42 eit), and the extra milk was he floor. ler temperature was 44 er buns were stored in d April 16, 2011, (the CDM burger buns.), and shredded d bag with ½ remaining had dated. et with solution was stored et with solution was stored d debris of white type of de. d full beard with no r the beard). et ice machine had dust stacked, one out of 9 had as one of 6 had dried		buns w Manage shredde by the I 5. The san the Diet 6. The mean Dietary 7. The diet 5/11/11 regardin wearing 8. The air v cleaned t 9. The stack removed Dietary M 10. Scales we into use b 11. The milk tray and d Manager of All Dietary staregarding all is Dietary Manag The Dietary Manag The Dietary Manag The Dietary Manager of andom checks. Secur five times to further issue thecks will occur ompliance. The	ment on 5/19/11. The base of cliscarded by the er on 5/9/11. The based cheese was proper Dietary Manager on 5/9/11 ary Manager on 5/9/11. The base of clienter was cleaned Manager on 5/9/11. The property of clienter was cleaned Manager on 5/9/11. The property cleaned by the Dietary Manage either shaving facing a beard cover. The property cleaned and property cleaned and property cleaned Manager on 5/9/11. The received on 5/9/11 are received on 5/9/11 are received on 5/9/11 are received on 5/9/11 are received on 5/9/11. The Dietary Manage was removed from the confidence of 5/11/11. The firms in-serviced by the Dietary Manager on 5/11/11.	Dietary g of ly labeled 5/9/11. noved by 11. by the viced on ger al hair or line were 9/11. diately d by the 1 and put ger. he test ary y 5/19/11 the ee will ure lking eeks. If om ensure		

TAG

(X5) COMPLETION DATE

05/17/2011 14:33

8655945,39

HEALTH CARE FACILITY

PAGE 29/42

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 05/18/2011 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. RUILDING B. WING 445383 NAME OF PROVIDER OR SUPPLIER 05/12/2011 STREET ADDRESS, CITY, STATE, ZIP CODE UNITED REGIONAL MEDICAL CENTER NURSING HOME

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX

1001 MCARTHUR DRIVE MANCHESTER, TN 37355 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE

F 371: Continued From page 24

beginning at 10:15 a.m., in the dietary department, confirmed no thermometer in the walk in freezer, peaches stored in can were out of date, the walk in cooler temperature of 42 degrees F, the extra milk was stored on the floor, the hamburger buns were to be thrown out, the shredded cheese had no date, a sanitizing bucket was stored next to the cooking oil, the meat slicer was unclean, and Dietary staff #1 had no protection on beard, and the air vents on the ice machine had dust accumulation, and the stacked pans had dried debris.

Observation of the meal lunch tray line on May 9, 2011, at 11:40 a.m., with the CDM, revealed Dietary staff #1 working the tray line with beard unprotected, and Dietary staff #2 working in the dietary department with beard unprotected. Interview with CDM at the time of the observation confirmed the staff had no protection on the beards.

Review of the facility's menus revealed "turkey w/ (with) cran glaze 3 ounces."

Observation of the lunch meal tray line on May 9, 2011, at 11:40 a.m., with the CDM revealed thin sliced turkey being served.

Interview with the CDM at the time of observation revealed the facility had no scale to measure the turkey being served.

Interview with resident #14 on May 10, 2011, at 9:00 a.m., in the beauty shop, revealed the resident stated the "turkey wasn't enough to feed a little dog."

F 371

ID PREFIX

TAG

The QA Committee will make recommendations and develop an action plan if areas of noncompliance are noted. The QA Committee meets quarterly and consists of the Administrator, DON, Assistant DON, MDS Coordinator, Medical Director, Social Services, Activity Director, Dietary Manager and others as indicated.

DEFICIENCY)

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: QZPF11

Facility ID: TN1601

If continuation sheet Page 25 of 32

05/17/2011 14:33 8655945/39

HEALTH CARE FACILITY

PAGE 30/42

DEP/	ARTMENT OF HEALT	H AND HUMAN SERVICES E & MEDICAID SERVICES	i			PRINTE	05/16/201	
LAINEN	ENT OF DEFICIENCIES IN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) I	VIULTIPLE CONSTRU	CTION	OMB NO (XS) DATE S COMPL	APPROVE 0. 0938-039 SURVEY ETED	
		445383	B, WI	NG		I	•	
	F PROVIDER OR SUPPLIER D REGIONAL MEDICAL	. CENTER NURSING HOME		1001 MCARTHU	, CITY, STATE, ZIP CODE IR DRIVE	05/12/2011		
(X4) ID PREFI) TAG		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		A, TN 37355 VIDER'S PLAN OF CORRECTOR ACTION SHO EFERENCED TO THE APPR DEFICIENCY)		COMPLETION DATE	
F 37	Observation of the I	preakfast tray line on May 1 in the dietary department,		71	·			
	Observation of a bre 2011, at 7:40 a.m., v room, revealed a car temperature of 47 de confirmed the tempe observation.	MIRAGE The ODL						
F 441 SS=F	483.65 INFECTION O SPREAD, LINENS	CONTROL, PREVENT	F 44	1 _{F441}			اداداد	
		ram designed to provide a nfortable environment and	n .	designed to comfortable	has established and Infection Control F provide a safe, sanita environment to help	Program		
	(1) Investigates, control in the facility:	lish an Infection Control it - ols, and prevents infections		prevent the of transmission All residents affected. All nursing s	levelopment and of disease and infect have the potential to taff will be in-service	etion.		
(a	Maintains a record of an actions related to infect			regarding per procedures.	e Director of Nursin i-care policies and benser was changed of	ıg		
d p	b) Preventing Spread of 1) When the Infection (etermines that a reside revent the spread of in olate the resident. () The facility must prof	Control Program ent needs isolation to fection, the facility must		The housekee maintenance or replace all soa	e Maintenance Direct ping supervisor and lirector are working to dispensers. The staff will be in-serving	to		

#545 P.031/043

05/17/2011 14:33 8655945739

HEALTH CARE FACILITY

PAGE 31/42

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 05/18/2011 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING 445383 B. WING NAME OF PROVIDER OR SUPPLIER 05/12/2011 STREET ADDRESS, CITY, STATE, ZIP CODE UNITED REGIONAL MEDICAL CENTER NURSING HOME 1001 MCARTHUR DRIVE MANCHESTER, TN 37355 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG PREFIX (X5) COMPLETION TAG DATE DEFICIENCY F 441 Continued From page 26 F 441 communicable disease or infected skin lesions by 6/3/11 regarding ensuring all soap from direct contact with residents or their food, if dispensers have soap in them. direct contact will transmit the disease. Resident # 19 was assessed with no (3) The facility must require staff to wash their adverse reactions from receiving an hands after each direct resident contact for which injection without the nurse wearing hand washing is indicated by accepted gloves. All licensed nursing staff will professional practice. be in-serviced on 5/25/11 by the DON regarding needle stick protocol. Personnel must handle, store, process and The laundry worker was in-serviced on transport linens so as to prevent the spread of 5/11/11 by the housekeeping supervisor infection. regarding policies and procedures. The laundry was rewashed 5/11/11 by the laundry worker. This REQUIREMENT is not met as evidenced Skills competency will be completed on all licensed nurses by 6/3/11 by the Based on medical record review, observation, Director of Nursing or her designee in facility policy review, and interview, the facility relation to hand washing and needle failed to maintain infection control for one resident stick protocol. Skills competency will (#9) for perineal care; failed to provide soap in bathroom for one resident (#23); failed to use be completed on all techs regarding gloves to give injection for one resident (#19) of peri-care by 6/3/11. twenty-three residents reviewed; failed to process Monitoring will occur five times per clothing in a sanitary manner and maintain the week times four weeks then weekly laundry department in a sanitary manner. times four weeks, and then random to ensure compliance by the DON or her The findings included: designee. Resident #9 was admitted to the facility on March The results of these checks will be 29, 2011, with diagnoses including Anxiety reported to the QA Committee quarterly. Disorder, Depression, and Muscle Weakness. The QA Committee will make Medical record review of the Minimum Data Set dated April 22, 2011, revealed the resident was recommendations and develop an action incontinent of bowel and bladder. plan if areas of noncompliance are

Observation on May 10, 2011, at 9:40 a.m., in the resident's room, revealed CNA #1 and CNA #2

noted. The QA Committee meets

HEALTH CARE FACILITY

PAGE 32/42

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 05/16/2011

	TEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA				FORM APPROVE OMB NO. 0938-038		
	PENN OF CORRECTION	DENTIFICATION NUMBER:	A. BUILDI		ICTION	(X3) DATE	SURVEY LETED	
NAN	E OF PROVIDER OR SUPPLIER	445383	B. WING			05	Malana	
UN	ITED REGIONAL MEDICA	L CENTER NURSING HOME		1001 MCARTH	CITY, STATE, ZIP CODE UR DRIVE R, TN 37355		12/2011	
PR		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)			VIDER'S PLAN OF CORRECTIVE ACTION SH REFERENCED TO THE APP DEFICIENCY)		COMPLETION DATE	
F	provide the care, us adjusted the control removed the resider gown on the resider side rail, and both C blanket. Continued removed gloves with the resident's supplike retrieved a wash cloreturned to the room resident's face. Review of the facility Precautions/Infection "handwashing1. It patients6. after removed hands after providing resident and had not washing the resident's Cobservation of a media 2011, at 8:25 a.m., in revealed LPN #1 (lices to the bathroom to wash out and stated there we bathroom and went to a hands before finishing the Interview with LPN #1 (Interview with LPN #1).	ssistant) providing the resident. Continued aboth CNAs wore gloves to sing the same gloves CNA #1 is for the bed, both CNAs int's gown and placed clean int; CNA #2 adjusted the bed in As adjusted the resident's observation revealed CNA #2 nout washing hands, placed es in the closet, left the room, the from the linen cart, and proceeded to wash the spolicy "Standard Control" revealed as for edirect contact with loving gloves." I and CNA #2 on May 10, the hallway, confirmed the ed gloves or disinfected incontinent care to the vashed hands prior to face. Cation pass on May 10, resident #23's room, ened practical nurse) went the hands. LPN #1 came as no soap available in the retrieve soap to wash the medication pass.	F 441	MDS Coo	and consists of the rator, DON, Assista ordinator, Medical I	ent DON,		

05/17/2011 14:33 8655945,39

HEALTH CARE FACILITY

PAGE 33/42

CENTE	RTMENT OF HEALT RS FOR MEDICAR	TH AND HUMAN SERVICES RE & MEDICAID SERVICES				PRINTEL	0: 05/16/20
SIMIEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTIO	n .	OMB NO (X3) DATE:	APPROVE 0. 0938-039 BURVEY ETED
		445383	B. WING_			1	
NAME OF	PROVIDER OR SUPPLIER					05/	2/2011
UNITED	REGIONAL MEDICA	L CENTER NURSING HOME] 10	001 MCARTHUR D			
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		R'S PLAN OF CORRE RECTIVE ACTION SH RENCED TO THE API DEFICIENCY)		COMPLETION DATE
F 441	Continued From pathroom.	age 28	F 441			-	
I do to the state of the state	administering medi- continued observal administered an inju- administered an inju- administered an inju- administered an inju- without applying glo Review of the facility Control/Needlestick the administration of the administration of the entire to we the receiver on May 10, 2, in the hallway, co- poplied when the insi- dministered. beservation on May the received the servation the provided the servation the provided the servation the provided observation the provid	y's policy Infection Protocol revealed "During f any injection nursing ar gloves as an added aployee and the resident" 2011, at 6:58 a.m., with LPN					

HEALTH CARE FACILITY

PAGE 34/42

_CE	PARTMENT OF HEALT. NTERS FOR MEDICAR	H AND HUMAN SERVICES E & MEDICAID SERVICES	3			PRINTE	D: 05/16/2	01
	EMENT OF DEFICIENCIES LAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(302)	MULTIPLE CONSTRU	ICTION	FORM APPRO OMB NO. 0938- (X3) DATE SURVEY		
		445383	B. W	JILDING		COMP	LETED	
NAME	OF PROVIDER OR SUPPLIER					05/	12/2011	
		CENTER NURSING HOME		STREET ADDRESS 1001 MCARTHI MANCHESTE	CITY, STATE, ZIP CODE			
PRE TA		ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	PRO	VIDER'S PLAN OF CORRECTOR ACTION SHO EFFERENCED TO THE APPR DEFICIENCY)		COMPLETIC DATE	NC
F4	arrives in the laundr opposite of the clear laundry comes in co is to be returned to it washed again as sociaundry and clean laundry and clean laundry and clean laundry duties are be laundry duties are be Review of facility policy should occur as soon buffer. After the padhad time to dry, the padhad time to dry, the padhad time to dry, the padhad time to may 11, 2 laundry worker #1, in the "sometimes may have clothes hamper in the clothes are in the prochung up."	slicy, Laundry Procedures and When the soiled laundry by room it is to be kept in laundry If at any time cle intact with the floor the iter its personal hamper to be son as possible Soiled undry are to never come in her: they are to be kept at the sible from each other when sing performed" cy, Buffer Pads Cleaning of the pad is taken off the has been cleaned and has add are to be bagged up to bags and stored" 2011, at 9:30 a.m., with the laundry room, revealed we dirty clothes in dirty laundry room while clean less of being washed and	an n	141				
F 514 SS=D	confirmed the sock had floor and then placed o the buffing pad were did 483.75(I)(1) RES	n the clean clother	F 514	F514		ما	13111	
	The facility must mainta resident in accordance standards and practices	in clinical records on each with accepted professional that are complete;		This facility records on ea accordance w	maintains clinical ach resident in with accepted			

HEALTH CARE FACILITY

PAGE 35/42

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES						PRINTEL	0: 05/18/2011 MAPPROVE D	
	AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRU A. BUILDING		CTION (X3) DATE		O. 0938-0391	
NAME OF	PROVIDER OR SUPPLIER	445383	B. WIN	G		1		
UNITED REGIONAL MEDICAL CENTER NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 1001 MCARTHUR DRIVE MANCHESTER, TN 37355			2/2011	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PRO	MIDER'S PLAN OF CORRECTOR SHO CORRECTIVE ACTION SHO EFERENCED TO THE APPR DEFICIENCY)		(XB) COMPLETION DATE	
	accurately documer systematically organ. The clinical record r information to identify resident's assessment services provided; transfer preadmission screen and progress notes.	nted; readily accessible; and nized. nust contain sufficient fy the resident; a record of the last the start of the last	F 51	that are condocument systematic Resident state of the Dir suffered in the missin licensed in	nal standards and promplete, accurately ed, readily accessible ally organized. 4 was assessed on ector of Nursing and adverse affect relig documentation. Aursing staff will be a 5/25/11 regarding	5/20/11 d ated to		
t d d d d d d d d d d d d d d d d d d d	Based on medical re the facility failed to er focumentation in the esident of twenty-thru the findings included: esident #4 was admit ovember 9, 2005, an ovember 9, 2005, an ovember 9, 2010, with d congestive Heart Faill ower Extremities, and	cord review and interview issure complete medical record for one (#4) are residents reviewed. Itted to the facility on direadmitted to the facility isgnoses including are, Lymphedema Bilateral I Diabetes.		All resident potential to The DON of monitor I & week then and then rate compliance. The results reported to quarterly.	ts on I & O have the beaffected. Or her designee will to O sheets five time weekly times four windom to ensure of these checks will the QA Committee.	es per veeks,		
Me Aprion and out recc 28,	take and output)" dical record review of the 7-3 shift. Medical Orecord dated Aproput documented on the large to the large the large to the larg	of a physician's order evealed "Strict I (and) O of the I and O record dated I no output documented al record review of the I ii 26, 2011, revealed no the 7-3 shift. Medical id O record dated April utput documented on the		an action planoncomplian Committee nonsists of the Assistant Do Medical Directors	mendations and de an if areas of nce are noted. The meets quarterly and he Administrator, I DN, MDS Coordina ector, Social Service ector and others as	QA OON,		

FORM OMS-2567(02-89) Previous Versions Obsolete

05/17/2011 14:33 8655945739

	17/2011 14:33	8655945739	н	EALTH CARE F	ACTI TTV			
DEPAI	RTMENT OF HEAL	TH AND HUMAN SERVICES		- LINE OF THE	HOILI IT		36/42	
-	-NO FOR MEDICAL	RE & MEDICAID SERVICES				PRINTE	D: 05/16/20	
TATEME	OF OF DEFICIENCIES	(X1) PROVIDER/SUPPLIED				OMR NO	M APPROVI 0. 0938-03	
ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				MULTIPLE CONST	RUCTION	OCAL DATE	7. 0938-03	
				A. RUILDING		(X3) DATE SURVEY COMPLETED		
		445383	8. W	NG		. 1		
	PROVIDER OR SUPPLIER					05/	12/2011	
(X4) ID		L CENTER NURSING HOME		I MCWAIL	SB, CITY, STATE, ZIP CODI TUR DRIVE	E	12011	
PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LISC (DEATHER)				MANCHESTER, TN 37355			
TAG	REGULATORY OR	T MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		OVIDER'S PLAN OF CORR CORRECTIVE ACTION SI REFERENCED TO THE AP DEFICIENCY)		COMPLETION DATE	
F 514	Continued From page 31			14	OLI ICIGNOT)			
	confirmed no document April 21, 2011 and	0, 2011, at 1:10 p.m., with the lursing) in the DON's office, mentation of the output on April 26, 2011, 7-3 shift and or						
]	April 28, 2011, 3-11	shift.						
		4						
					4			
1								
İ		*		1				
-		1		1		- 1	i	
		1		ŀ		1	- 1	
						1	- 1	
							- 1	
į						1]	
			1			- 1	- 1	
		1	1			1	- 1	
		i	ir.				- 1	
1			1				- 1	
1					×		- 1	
		1						
			- 1				- 1	
	*		. }					
			-			1	- 1	
400			- 1		i			

Event ID: QZPF11

Facility ID: TN1601

If continuation sheet Page 32 of 32